

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/07/2025
NAME OF PROVIDER OR SUPPLIER  Hillcrest Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  100 Little Drive Lower Burrell, PA 15068	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>Based on a review of facility policy, facility documents and staff interviews, it was determined that the facility failed to document the date the grievance was received, a summary statement of the resident's grievance, steps taken to investigate the grievance, a summary of findings/conclusions regarding the resident's grievance, whether the grievance was confirmed or not confirmed, corrective actions implemented, and the date of written decision issued for one of one resident's (Resident R1) allegation of neglect. (Resident R1)</p> <p>Findings include:</p> <p>A review of facility Grievance/Complaints, Filing policy dated 2/20/25. revealed upon receiving a resident grievance or complaint the facility Grievance Officer will submit a written report of the findings of the Administrator.</p> <p>A review of a facility reported document dated 4/5/25, to the State Agency contained an allegation of neglect by Resident R1. The report contained evidence that Resident R1 made an allegation that facility staff allowed her to lay on the floor for an hour after a fall.</p> <p>A review of facility Grievance Log for the month of April failed to provide documented evidence that the facility documented a summary of the resident's allegation, investigate the allegation, document a summary of findings/conclusions, if the allegation was substantiated or unsubstantiated, corrective actions implemented by the facility, and the date the decision was issued.</p> <p>During an interview on 5/7/25, at 10:56 am the Administrator in Training Employee E2 confirmed that the facility's April 2025 Grievance Log failed to provide documented evidence that the facility implemented and completed the grievance process which included properly documenting the resident's allegation, investigate the allegation, complete a summary of findings, draw a conclusion of substantiated or unsubstantiated and provide a date when a decision was issued.</p> <p>Pa Code:201.29 (a) Resident Rights</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>Based on a review of facility policies, documents, resident and staff interviews, it was determined that the facility failed to implement an abuse/neglect policy that thoroughly investigated allegations for one of one event with allegations of neglect. (4/5/25).</p> <p>Findings include:</p> <p>A review of facility Abuse Investigation and Reporting policy dated 2/20/25, indicated all parties will be interviewed to obtain information regarding the allegation, all witness statements will be obtained in writing with signature and date of the witness, at the completion documents will be completed and reviewed with the Administrator.</p> <p>A review of facility documents dated 4/5/25, submitted to the State Agency revealed that Resident R1 voiced a concern that staff allowed her to remain on the floor for an hour after sustaining a fall.</p> <p>A review of facility witness statements failed to provide a written document of witness statements obtained of the resident and her roommate which created an incomplete investigation.</p> <p>A review of facility documents revealed that the facility failure to follow the guidance and procedures of the Abuse Investigation and Reporting policy created the potential for an improper thorough investigation which failed to identify alleged perpetrators related to Resident R1's allegation of neglect.</p> <p>During an interview with the Chief Nursing Officer Employee E1 and a state surveyor on 5/5/25, at approximately 1:45 pm Resident R1 identified the staff members that allowed her to lay on the floor as the Director of Nursing and two Nurse Assistants.</p> <p>During an interview on 5/7/25, at 10:57 am the information of the facility's failure to implement the facility's Abuse, Investigation and Reporting policy which provided guidance and procedures on conducting a through investigation was reviewed with the Chief Nursing Officer Employee E1 and the Administrator in Training Employee E2.</p> <p>Pa Code 201.14(a) Responsibility of Licensee</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on a review of facility policies, documents and resident and staff interviews, it was determined that the facility failed to provide evidence that an alleged allegation of neglect for one of one event (4/5/25), was thoroughly investigated as required.</p> <p>Findings include:</p> <p>A review of facility Abuse, Investigation, and Reporting' policy dated 2/20/25, indicated that all allegations of abuse/neglect will be thoroughly investigated by Administration.</p> <p>A review of facility documents dated 4/5/25, submitted to the State Agency revealed that Resident R1 voiced a concern that staff allowed her to remain on the floor for an hour after sustaining a fall.</p> <p>A review of the facility's investigation of Resident R1's allegation of neglect revealed the following:</p> <ul style="list-style-type: none"> <li>* The facility failed to complete documentation of the resident's grievance.</li> <li>* The facility failed to interview the resident and her roommate which created an incomplete and inaccurate conclusion of the facility not identifying alleged perpetrators.</li> <li>* The facility failed to properly investigate the resident's allegation of neglect which resulted in the facility's failure to identify alleged perpetrators and submit PB22 documents to the state agency as required.</li> <li>* The facility failed to implement their plan of correction for a citation (F600) regarding making certain that the resident's are free from abuse/neglect issued on the completion of a survey ending on 3/7/25.</li> <li>* The facility's lack of a thorough investigation created the potential for improper implementation of corrective action including the prevention of further alleged abuse/neglect.</li> </ul> <p>During an interview with the Chief Nursing Officer Employee E1 and a state surveyor on 5/5/25, at approximately 1:45 pm Resident R1 identified the staff members that allowed her to lay on the floor as the Director of Nursing and two Nurse Assistants.</p> <p>During an interview on 5/7/25, at 10:57 am the information of the facility's failure to properly investigate, prevent and correct allegations of abuse/neglect by the facility's failure to conduct a through investigation was reviewed with the Chief Nursing Officer Employee E1 and the Administrator in Training Employee E2.</p> <p>Pa Code 201.18(b)(1) Management</p>		